STATE OF MONTANA
DEPARTMENT OF LABOR & INDUSTRY
HEALTH CARE LICENSE BUREAU
301 S PARK AVE, 4TH FLOOR
PO BOX 200513
HELENA, MONTANA 59620-0513
(406) 841-2300

FOR OFFICE USE ONLY

Complaint #_____

COMPLAINT AGAINST: _____ LICENSE # _____
(If Known)

PROFESSION/OCCUPATION TYPE: _____

BUSINESS/FIRM NAME: _____ PHONE # _____

ADDRESS: _____
Street # or PO Box *City/State* *Zip Code*

If applicable:
PATIENT NAME: _____ DATE OF BIRTH: _____

NATURE OF COMPLAINT: *Please describe in detail the nature of the complaint, giving dates and other information. If service is part of the complaint, give information about telephone calls, contracts, etc. Attach additional sheet if necessary.*

_____
_____
_____
_____
_____
_____
_____

LIST OF WITNESSES AND EVIDENCE: _____
_____
_____

WHAT ACTION ARE YOU REQUESTING OF THE BOARD OR DEPARTMENT? _____
_____
_____

The facts and matters contained herein are true, accurate and correct to the best of my knowledge.

YOUR NAME: _____ PHONE#: _____
Print Here

YOUR ADDRESS: _____
Street # or PO Box *City/State* *Zip Code*

I hereby authorize the release of all my protected health information maintained by any and all my healthcare providers to the above-named licensing board and its agents. This authorization shall be in effect until the licensing board has concluded all actions concerning this complaint.

COMPLAINANT'S SIGNATURE: _____ DATE: _____

Subscribed and Sworn to before me the _____ day of _____, _____

NOTARY SEAL

_____
Notary Public for the State of Montana
Residing at _____
My Commission Expires _____

Updated 07/2004